*Printed Patient Name:	*Date of Birth:
*Address:	*Telephone Number: (_____)_____
*City: _____ *State: _____ *Zip Code:_____	

*I hereby authorize _____ to release and exchange written, oral or electronically transmitted
(facility name)
protected health information indicated below on the above named individual to:

* RECORD COPY SERVICES
Provider Name/Organization/Individual

* 30 N LA SALLE ST S-1800
Full address of Provider/Organization/Individual

*City: CHICAGO *State: IL *Zip Code: 60602 *Telephone #: (312) 726-6650

*Including information related to: ☐ Psychiatric Care & Treatment ☐ Substance Abuse Care & Treatment ☐ Medical Care & Treatment

*For the following purpose: ☐ Physician or Health Care Facility ☐ Legal Purposes ☐ Personal Use ☐ Follow-up Care ☐ Tuition Payment ☐ School Staffing ☐ Placement ☐ Insurance Determination ☐ Vocational Service Referral ☐ Continuity of Care ☐ At Request of the Individual ☐ Primary Care Physician ☐ Other(Specify)_____

*Treatment date(s): _____ *Date Authorization Expires: _____
Treatment Date(s) must include month and/or year (1 year maximum)

***INFORMATION TO BE DISCLOSED:**

☐ Dates of Admission & Discharge	☐ Discharge Summary	☐ Speech & Language Eval.	☐ Attendance
☐ Face Sheet	☐ Psychiatric Evaluation	☐ Laboratory Results	☐ Medication Information
☐ History and Physical	☐ Psychological Evaluation	☐ Radiology Reports	☐ Psychiatric Diagnosis
☐ Physical Health Screen	☐ Psychosocial Assessment	☐ Treatment Update	☐ Treatment Information
☐ Consultation	☐ Level of Care Screening	☐ Progress Notes	☐ Follow-up care
☐ Admission Assessment	☐ Other (Specify) _____		☐ Chemical Dependency Diagnosis
			☐ Medical Conditions and / or Diagnosis
☐ **HIV Documentation _____(Must Initial)**			☐ Homework information
			☐ IEP or 504 Plan Information
			☐ School Information Form

Work Letter MAY Disclose Treatment Type and Facility _____ (Must Initial)
Work Letter MAY NOT Disclose Treatment Type and Facility _____ (Must Initial)

WORK LETTERS ARE NOT TO BE FAXED THEY MUST BE PICKED UP BY PATIENT

I understand that:

- **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.
- The Consequences of my refusal to sign, if any are:_____

_____ _____ _____ _____
* (Signature of patient) * (Date) (Signature Parent or Legal Representative) (Date)

(Patients l2 to l7 years of age must sign in addition to the Parent or Legal/Personal Representative)

_____ _____
* (Witness Signature) * (Date)

(If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILIY USE: Date received: _____ Date completed: _____ MR #: _____
When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: ☐ Driver's License ☐ Picture ID ☐ Legal guardian ☐ Court appointed legal guardian
☐Power of Attorney ☐ Executor of Estate ☐Other: _____
Person/Department completing the request:_____

Authorization to Disclose Protected Health Information

Alexian Brothers Behavioral Health Hospital
1650 Moon Lake Blvd.
Hoffman Estates, IL 60169

Alexian Brothers Behavioral Health Group Practice
1786 Moon Lake Blvd.
Hoffman Estates, IL 60169

Authorization to Disclose PHI
Form #9060-010 06/11
Chart copy - Patient copy - Mail out Request Records copy

PDDL

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